NOVEMBER 1956

Mental Hospitals

THE HOSPITAL SUPPLY SYSTEM

A NEW TOOL IN PSYCHIATRIC EDUCATION

INTEGRATION OF A RESEARCH DIVISION IN A GENERAL MENTAL HOSPITAL

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American Psychiatric Association

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Mental Hospitals

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INSTITUTE HIGHLIGHTS

This year the Achievement Award was of considerable local interest in Colorado, since it went to the Veterans Administration Hospital at Fort Lyon. Some thirty or forty staff members drove into Denver for the presentation. The cover picture shows Dr. Howard P. Morgan, the hospital's manager, on the extreme left; Dr. J. M. Mosier, Superintendent, Indiana Village for Epileptics, New Castle and Dr. Peter Bowman, Superintendent of Pownal State School, Maine, are holding the Honorable Mention Certificates won by their institutions. Traditionally Dr. Daniel Blain, who presented the Award and Certificates, was photographed with the winners. (See P. 17 for other Institute pictures.)

The final count on the 8th Mental Hospital Institute was 404, the second largest number of delegates at any Institute. Of the delegates, 212 were physicians, 75 were business administrators on a state or hospital level, and 34 were nurses. The rest came from other disciplines and from related agencies.

The Academic Lecture was given by Dr. Stewart Wolf of the University of Oklahoma School of Medicine, on "The Scientific Attitude in the Evaluation of New Drugs, with Special Reference to the Tranquilizing Drugs."

President Francis J. Braceland's after-dinner address was on "Comprehensive Psychiatry and the Mental Hospitals." In this talk Doctor Braceland pursued the theme that little was new under the sun. It seems as though modern mental hospitals, in their interest in social psychiatry, are going back to "moral treatment", but on a higher scientific level of the spiral. Today a "therapeutic milieu" can be better evaluated and implemented. He also renewed his plea for more young physicians to enter the mental hospital field, saying that here was the challenge and here was the need.

In addition to the four local hospitals scheduled for visits, three out-of-town institutions—Pueblo State Hospital, VA Hospital, Fort Lyon and the Wheatridge Training School—made special arrangements for those who wished to go. For these and other arrangements, we are greatly indebted to our Local Arrangements Committee, especially the co-chairmen, Dr. Herbert S. Gaskill and Dr. Frank Zimmerman.

Three optional programs drew large numbers of delegates: the business managers' meeting which is to become an annual event; the Commissioners' meeting, and the presentation of the Saskatchewan Plan.

From the point of view of the staff of the Mental Hospital Service, one of the most productive of the meetings was the informal gathering of its Contributing Editors, without whose efforts the magazine and Service would be much poorer. It is planned to give a longer time for this discussion at the next Institute.

Once again the Proceedings of the Institute will be published in the February issue of MENTAL HOSPITALS. Copies will be sent to each delegate who attended.

No. 12 in a Series on Mental Hospital Administration

THE HOSPITAL SUPPLY SYSTEM

Procurement, warehousing, issue and control of supplies and equipment

By CARL E. APPLEGATE

Deputy Director, Business Services
California Department of Mental Hygiene

THE ROLE OF ANY HOSPITAL is to provide the physical facilities as well as the professional services required in the treatment and care of the sick. If the staff is to perform its professional duties, equipment and supplies must flow in an orderly system to all departments of the organization.

1. *Medical Service*: Unquestionably the fundamental service of any hospital is that rendered by its medical and nursing staff. The equipment, drugs and materials used by this service present a formidable list.

2. *Dietary Service*: This requires the establishment of warehouses, completely equipped food-preparation centers, dining areas, and the procurement and continuous flow of foodstuffs in the proper quantities.

3. *Clothing Service*: The importance of this service is greater in state hospitals, where clothing is furnished to a large segment of the patients, but all types of hospitals require the procurement of clothing for surgical and feeding services.

4. *Housekeeping Service*: This requires the supplying of all furnishings, including beds, bedding, and all ward materiel, as well as equipment and supplies used in day-to-day cleaning operations.

5. *Laundry Service*: In most hospitals this is performed on the hospital premises. It entails proper marking, the supplying and condemnation of linens, and sterilization procedures of possibly higher standards than those normally found in commercial laundries.

6. *Maintenance Service*: While this service is not directly connected with the care of the patient, his treatment, comfort and safety require the procurement of vast amounts of supplies and equipment and the proper scheduling of preventive maintenance work to the entire hospital plant.

It is recognized that the procurement, warehousing and distribution systems of hospitals must vary, depending upon whether the installation is a small privately-owned hospital or a large public institution; on its location; physical layout; climatic conditions; local trade practices; and the type of patients cared for.

The small privately-owned hospital would normally make most purchases in the local community and stock only sufficient supplies to take care of immediate needs. The large public hospital must comply with the laws and regulations of its governing body and must purchase in accordance with budgetary allowances.

The principles in such a system, which is applicable to state-operated or federal-operated hospitals, may also be applicable to other hospitals. To consider such a system in its logical sequence, we must consider the establishment and operation of:

1. A budget with allotments and complements for each function;
2. A food control or ration system based on the budget;
3. Standard specifications for various commodities;
4. A central purchasing department and methods of buying;
5. Stores—the requisition, receipt of and payment for materiel;
6. Proper warehousing of purchased and produced commodities;
7. A method of issuing supplies and equipment based on stores requisitions;
8. A method of controlling and accounting for equipment and supplies.

Budget Allotments and Complements

All governmental organizations operate on the budget system with allotments of funds for each function; such allotments are based on past experience and future needs. From the detailed allotment requests of an agency, an appropriation is made by the legislative body, which is then broken down to functions and sub-functions and set up in encumbrance registers against which contemplated expenditures may be charged.

When constructing a new ward or building in a hospital, a complete, priced list of equipment and a complement of operating supplies should be established. The list may be made up from the architect's preliminary plans of the building and will serve to substantiate the request for an appropriation to equip the structure. Similarly, each ward or unit of a hospital should have complements of expendable equipment and materials, such as linens, towels, bedding, tableware, small tools, etc. which are not accounted in the equipment inventory but which complements are maintained by replacements as needed. Complements for wards will, of course, depend on the size of the ward and the class of patient. The normal replacements will determine the pattern of

usage for any given item in the complement, and the amounts to be purchased for a given period.

Food Control

The determination of the required types and quantities of food, its storage, and the preparation and serving of nutritious meals is a major function in the hospital operation. Although the dietary service should be the responsibility of the dietitian under the direction of the medical authority, procurement and warehousing of food is properly discussed here. Once the feeding level is established, the amount of food required for a given length of time to supply nutrition at the level designated by the medical service can be established.

This amount can be set up by food groups or by individual food items and can be established on a quarterly, monthly or weekly basis, depending upon the frequency of purchases. Various diets should be established—general, therapeutic, tuberculosis, industrial therapy, children, nursery and geriatric, as well as diets for the employees.

Through food accounting that meets the schedule of food rations, the hospital will be able to evaluate the nutritional value of food served. Menus may be set up six weeks in advance, recipes determined, and then converted to commodities to be purchased and the costs established.

Standard Specifications

While there may be some opposition to the standardization of goods purchased for hospital use, such a system has many advantages. Among these are the development of the best product to fit the particular needs, mass production at a lower cost, reduction of the number of items carried in stock, faster turnover of stores stock, and economic utilization of warehouse space.

A file of specifications should be established for all frequently used commodities. These specifications can be developed by the central purchasing department or by representatives of various state agencies working with the purchasing department. The specifications prepared by the General Services Administration of the Federal Government could be consulted and those produced by a number of national trade associations may be used where standards for technical commodities are needed.

The development of specifications is a continuing process, requiring changes as new commodities or variations of existing commodities become available. The State of California has eight categories of specifications and over 450 individual specifications which have been published. These are in addition to the national trade associations' specifications for technical materials. This manual of specifications is available to all departments of the state and copies are sent to vendors interested in bidding on the various classes of items.

Central Purchasing Department

The fundamental objective in the establishment of a central purchasing department is to obtain economies through mass buying directly from the manufacturer wherever possible. A central purchasing department will provide for commodity standardization, allow for purchasing by contract in larger quantities and at better prices, and reduce the overhead of each agency performing its own purchasing function.

A central purchasing department also has the benefit of trained buyers devoting full time to that function and providing vendors with a single source for negotiations. It is understood, of course, that hospital personnel can discuss products with salesmen, can take part in developing specifications, and can indicate the type of commodities they wish.

Under a law passed by the California Legislature in 1955, amendments were made to the existing Purchasing Act which provide that, except in cases of emergency, all purchases over $25 shall be under the supervision of the purchasing department, and that sealed bids shall be taken by the purchasing department for all commodities costing over $1,000, with contracts awarded to the lowest responsible bidder.

The principal amendment to the Act is the establishment of a purchases standards committee consisting of state officials and citizens. The committee is required to establish standard specifications; however, the Act allows the state agency for which the purchase is made to specify the quality of the commodity to be purchased. If any differences arise between the agency, the purchasing department, or the vendor, the State Board of Control shall grant a hearing to determine the issues. The effect of this is to curtail substitutions and provide the agency with the type of commodity desired.

The central purchasing department should be the only agency authorized to enter into contracts for commodities over an extended period, such as yearly contracts for specific commodities. After the contracts are negotiated, all agencies are then notified of the terms of each standing contract and the individual agency or hospital can then issue sub-purchase orders against the existing contracts for the amounts required and for delivery at times desired.

In cases of emergency, or for the protection of public health or safety, hospitals are allowed to make purchases direct on the open market by issuance of sub-purchase orders without bids up to specified maximum amounts.

A hospital or agency of a governmental organization should have the power to specify that no substitutions may be made by the central purchasing department for certain commodities, such as brand names of drugs or where items of equipment must be inter-membered with existing equipment.

In most states the penal institutions manufacture commodities for sale to hospitals or other governmental organizations. This provides industry and pay for the penal inmates, but prison industry must compete with private industry as to price, quality, and delivery.

The fluctuations in price of certain commodities and types of items will influence the span of ordering. For the purchase of commodities having a fairly stable price, other than yearly contract items, bids can be taken for a quarterly period or longer; those of less stable price can be purchased monthly; and for commodities such as butter, eggs, milk, etc., purchases may have to be made based on market quotations at the time of delivery. To avoid loss from deterioration, care should be taken

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In similar studies, the worst behavior problems in the hospital showed improvement, chiefly ". . . a reduction of motor activity, of tension, of hostility, and aggressiveness."[2] Many reports have indicated that Serpasil may be substituted for electro- or insulin shock and that it sharply reduces destruction and assaults in the violent back wards.

Adequate trial is essential—a minimum of 3 months, beginning with "parenteral doses of at least 5 mg. of reserpine and continued daily doses of 2 to 8 mg. orally."[1] "The occurrence of the turbulent phase (with exaggeration of symptoms) is *not* an indication for discontinuing treatment."[3]

1. Hollister, L. E., Krieger, G. E., Kringel, A., and Roberts, R. H.: Ann. New York Acad. Sc. *61*:92 (April 15) 1955. 2. Hoffman, J. L., and Konchegul, L.: Ann. New York Acad. Sc. *61*:144 (April 15) 1955. 3. Kline, N. S., and Stanley, A. M.: Ann. New York Acad. Sc. *61*:85 (April 15) 1955.

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not to purchase in too large quantities. Packages should be of a size that can be readily used, as repackaging is expensive in labor, materials, and loss in dispensing.

Requisition, Receipt and Payment for Materiel

In government hospitals, requisitions for supplies usually cover a quarterly period, and orders are issued by the purchasing department for that period, although deliveries may be taken daily, weekly, or monthly. Requisitions for foodstuffs should be based on the expected population, the established ration, the quantities on hand, and the commodities produced by the hospital.

Requisitions are then priced according to the latest information, submitted to the accounting officer for encumbrance against available budget allotments, and then submitted through channels to the central purchasing agent. All materials or equipment, both purchased or locally produced, should be delivered to the storekeeper of the hospital, who is held responsible for all items received.

Copies of all purchase orders should be available to the storekeeper, and when commodities are delivered, he will check the quantities, weights, and quality against the purchase order. If materials are not in accordance with the purchase order, they should be returned at the expense of the vendor, and the purchasing agent notified. If there is doubt as to the quality of food, chemicals, etc., samples should be sent to the Department of Public Health for analysis and report.

A stock-received report showing the exact count and weight should be made out by the storekeeper for all commodities received. This report should be forwarded to the accounting officer so it can be checked with the vendor's invoice. Payment should be made only for the amounts shown on the stock-received report. Both the storekeeper and the accounting officer must be careful to see that the stock-received report and the invoice are processed without delay in order to take advantage of any cash discount allowed.

Warehousing

Although a centralized purchasing department is proposed here, there is no such endorsement for a statewide centralized warehousing function. Warehouses can be set up in each hospital patterned to the size of that hospital without the necessity of superimposing a statewide system of warehousing. Commodities can be ordered by each hospital against purchase orders in the quantities required to maintain a constant flow of materiel through the hospital warehouse. Excessive inventories can be controlled in a hospital warehouse by the storekeeper, as in a large statewide central warehouse. The hospital storekeeper should be responsible to the business manager, or to a higher authority than a food administrator, chief engineer, or any department head in the hospital, who may issue requisitions to the warehouse. The size of the warehouse or storage facilities in the hospital, particularly those caring for foodstuffs, will depend upon the frequency of deliveries.

The warehouses in a hospital are of five major types:

1. A central warehouse caring for most foodstuffs;
2. A clothing, linen, and housekeeping supply area;
3. Engineer's warehouse where all maintenance and construction materials are stored;
4. Farm warehouse where locally produced or purchased farm feeds are stored;
5. Property warehouse where beds, furnishings, or similar equipment is kept.

From these warehouses commodities are issued on stores requisitions for direct usage or to sub-store rooms, such as the butcher shop, bakery, kitchen (not exceeding one week's supply), the various maintenance shops such as carpenter, painter, plumber, etc., and the farm units.

Fresh meats are normally received weekly and an allowance made of three additional days so that ten-day-old seasoned meat is used by the butcher shop. Meats are normally stored in refrigerators adjacent to the butcher shop rather than in the general warehouse, but are still under the control of the storekeeper.

General warehouses or commissaries need not be of expensive construction. Prefabricated metal buildings may suffice, depending upon the climatic conditions. Provision should be made for dock-loading areas sufficient to accommodate four to six auto trucks or several freight cars. Truck scales should be provided for weighing in loads of both purchased and locally-produced commodities. (All scales in the hospital should be checked periodically for accuracy by the state authority having jurisdiction over this function.)

The general commissary should be located as close to the food service unit as possible. Most commodities should be received either on pallets from the delivery trucks or freight cars, or stacked on pallets on the loading dock where the hospital forklift truck will transport the loaded pallets to their proper destination in the warehouse. Similarly, pallets of foodstuffs can be delivered from the commissary to the kitchen by the hospital forklift. Steel racks can be constructed in the warehouse in which loaded pallets four high can be inserted by the forklift truck. All storerooms should be mechanized by forklift trucks, belt conveyors, and other such equipment as is used in commercial warehouses.

Appropriate facilities should be constructed in the warehouses to provide adequate storage for all commodities, with bins, shelves, and racks on which cards indicate the standard stock for each commodity and the point at which re-ordering is necessary.

Refrigerated areas at various temperature levels should be provided in the food warehouse. Temperatures for specific commodities are defined by the State Department of Public Health and the U.S. Department of Agriculture. The amount of cold storage areas will depend upon the frequency of delivery.

An area should be set up where patients can be fitted for the clothing issued to them. Physicians agree that it is good for patients to have the privilege of selecting the style and color of their clothing. The hospital chiropodist, or a capable substitute, should individually fit each pair of shoes issued to patients.

A canteen should be set up in each large hospital either as a subsidiary to the storeroom, as a separate corporation under the control of the hospital, or as a concession. This will provide the many little things that enhance the comfort and well-being of the patients, and also prove a convenience to the employees and visi-

tors. A patients' welfare fund can be established with profits from the operation of the canteen to furnish extra holiday treats, entertainment, etc.

Issuance of Commodities

As indicated above, all commodities received by the hospital are the responsibility of the storekeeper and no item can be issued from the store except on an approved requisition. In instances where a commodity must be delivered directly to a particular section of the hospital, the storekeeper makes out a stock-received report, as well as a requisition for the item, and the receiving section will check in and sign for the commodity. It is only through a requisition system that the cost of operation of the various units of the hospital can be determined.

Locally manufactured items, such as clothing, bedding, and cannery products, are also accounted through the stores system by the issuance of materials to the manufacturing unit on requisitions, and receiving the finished products by stock-received reports at the actual value of the materials. Commodities produced on the farms, such as fruit, vegetables, pork, milk and eggs, are accounted through the commissary records at current wholesale prices and the feeding unit of the hospital is charged with the value of the items supplied. All costs of producing such farm commodities are charged to the farming unit. In this manner a determination can be made as to whether the farming operations are profitable.

Many hospitals are reducing or discontinuing farming operations, which is a step in the right direction. Mental hospitals are for the purpose of treating and releasing patients and are not for operating farms in competition with private industry. No hospital should produce commodities for sale in the market but should limit its operations to its own needs.

Each ward should have a standard complement of linens, bedding, medical and housekeeping supplies based on the type of patient, number of beds, bed changes normally required, and the number of baths per week. This complement should be kept up to date. Requisitions on the commissary for supplies to maintain the complement are issued daily, weekly, or monthly, depending upon the commodity, such as drugs and prescriptions, supplemental foods, housekeeping, clothing, or office supplies. Complements of bedding and some articles of clothing are kept up to date by delivery to the laundry of soiled linens and the immediate return of a like number of items from the laundry stock.

A manual of operations should be established for each ward in a hospital, indicating definite times for requisitioning various types of supplies. There is a tendency in some wards to hoard supplies against a shortage. If a storeroom can always fill approved orders for supplies, the tendency to hoard will be reduced. Similarly, the laundry exchange system tends to reduce the hoarding of linens.

To maintain a control of stores stock, physical inventories should be taken monthly or on a rotating basis and reconciled with the stock record cards. This will not only aid in keeping stocks up to date but it will determine if the food supplies are being used according to the food control.

Control of and Accounting for Equipment and Supplies

Much could be written on the various phases of this topic. Briefly, it is apparent that all supplies as well as equipment should flow through the storeroom system, with the storekeeper being responsible for their receipt and issuance. Equipment items should be completely recorded on property record cards when received and added to the inventory of the hospital. All equipment should be properly identified by tagging or marking with decalcomania, metal tags, stencils, or branded or painted, depending upon the type of equipment, and the assigned number placed on the property record cards.

Inventories of the various units of a hospital should be taken on a rotating basis, with each unit being checked yearly. While supplies are disposed of by requisitions issued on the storeroom, equipment can only be disposed of through a survey and condemnation system which eliminates the item from the inventory.

A Board of Survey, of which the storekeeper is a member, should be set up to survey all equipment and recommend its condemnation or sale. A central exchange system in the laundry will aid in the control and survey of linens, bedding and some articles of clothing. Materials received by the laundry which require mending should be sent to the mending room, while those beyond repair should be condemned and disposed of by the Board of Survey, and replacement items issued.

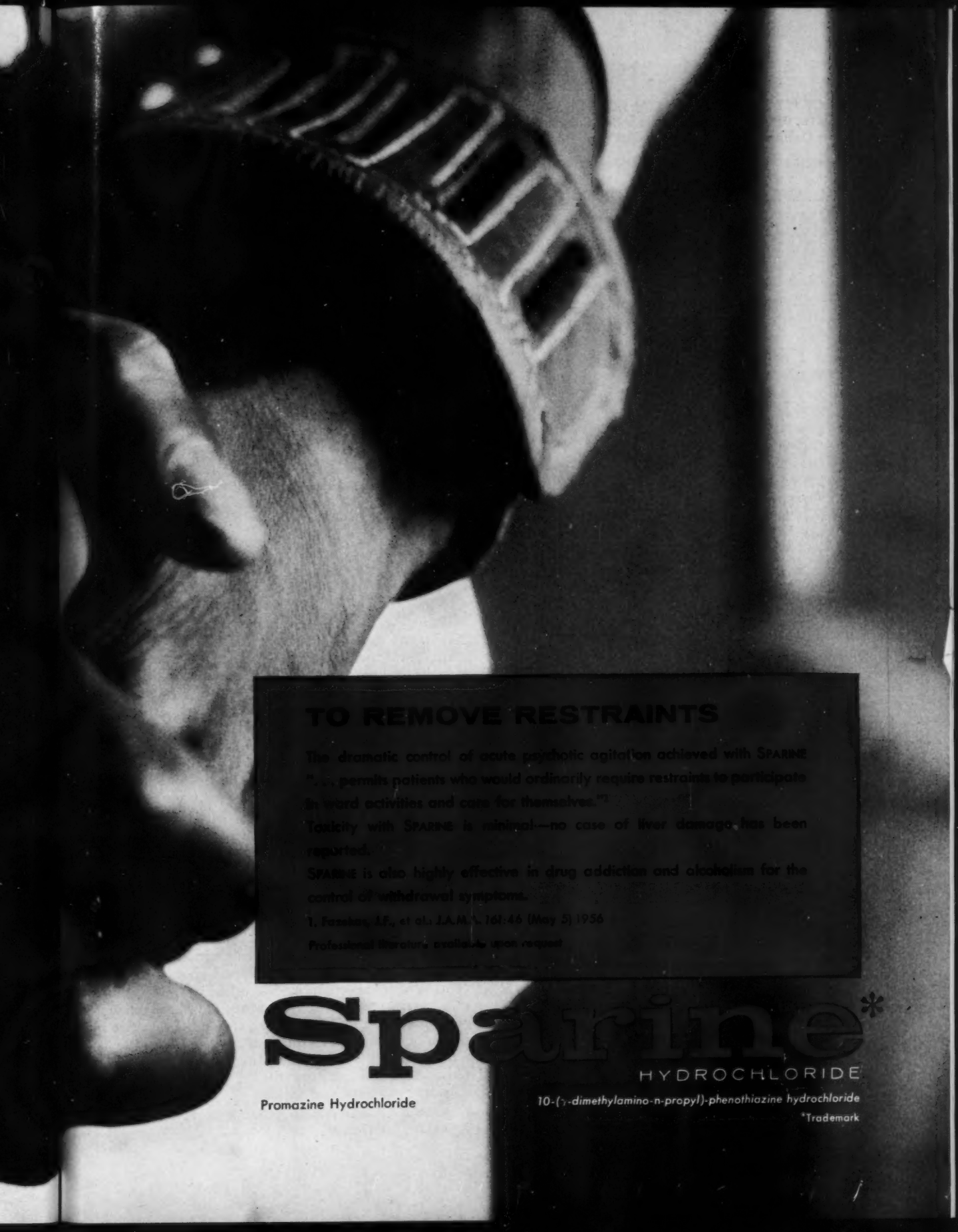
To aid further in the control of linens, bedding and clothing, a marking system should be established whereby patients' personally-owned clothing, as well as hospital-furnished garments, are identified by the patient's name and ward printed on a tape and sewed in the garment. Linens and bedding issued through the laundry control exchange should first be marked with the name of the hospital and date the article was placed in service.

As an aid to the security of the hospital's supplies and equipment, several suggestions are given:

1. The storeroom of the hospital should be locked and admittance granted only to authorized personnel.
2. Commodities should be issued only by properly approved requisitions.
3. Areas in kitchen storerooms or on wards where foods are kept should be available only to the supervisor of the unit (such as the head cook having charge of the weekly kitchen storeroom).
4. Food commodities should be requistioned from the central commissary for weekly kitchen stores in accordance with recipes previously established.
5. Keys should not be taken off the grounds of a hospital, but should be desposited at a central station by all employees as they go off duty.
6. Depending upon the laws of the state, a hospital should have the right of search of persons and vehicles leaving the hospital premises.

An endeavor has been made here to point out some of the fundamentals of a system that can be applied to a large governmental hospital. To cover the details of a complete system would require volumes; however, it is felt that there is not in existence a single system that can be said to be a panacea for the ills of every hospital's supply and distribution problems.


Wyeth
Philadelphia 1, Pa



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1. Feinberg, A.R., et al.: J.A.M.A. 161:46 (May 5) 1956

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*Trademark

Book Review

PRACTICE OF PSYCHIATRY IN GENERAL HOSPITALS—A. E. Bennett, M.D., E. A. Hargrove, M.D., Bernice Engle and contributing authors. University of California Press, Berkeley, California. 1956. $4.00.

Dr. Bennett and his co-authors have covered the various arguments for and against the inclusion of psychiatric units in general hospitals. They have made a good case for the general hospital that wants to live up to its name and accept all types of illness. It would appear that ignorance about mental illness is still the greatest deterrent to the expansion of psychiatric services in the general hospital field.

The staffing patterns and the training of adequate staff is the theme of the first portion of the book. Citing the shortage of trained personnel, the authors recommend sending good nurses for training to other hospitals and then using these as a nucleus to train others. In order to make it worthwhile to have half-time or full-time ancillary personnel, units of less than 15 beds are not recommended.

A chapter on architecture with type plans of typical units and rooms is included. Descriptions of the various types of nursing units that might be used for different kinds of patients stress the importance of proper planning before the architect draws the preliminary plans.

Medico-legal aspects of patient care with special reference to injuries to the patient or by the patient to others bring out some of the security problems involved. Suicides and elopements are also discussed.

The impact of this program on prepayment insurance plans such as Blue Cross is discussed and the inadequate coverage of mental illness is pointed out by many examples.

The inclusion of a Day Hospital in the program is discussed with the idea of making psychiatric services available to many patients who might not be reached otherwise.

The final chapter takes up special types of treatment such as chemotherapy and group psychotherapy, and the treatment of special groups such as alcoholics and geriatric patients.

A bibliography of pertinent current literature is included at the end of each chapter and a subject index is included at the end of the book.

This book is timely and should be read by all general hospital administrators. The number of psychiatric units in general hospitals is rapidly rising and may eventually relieve the overburdened state hospitals of some of their load by early treatment of mental illnesses to avoid long custodial care.

CHARLES K. BUSH, M.D.
Washington, D. C.

A DEAD DUCK?

Dr. Whatsisname

THE HEALING WATERS have lost their enchantment. Though spas have been with us since the dawn of man, they are now being down-graded to make way for drugs, electronic therapies, psychosurgery and psychotherapy.

Even as recently as the end of World War II, mental hospitals had large hydrotherapy units built in from the ground up. Hydrotherapy was always a good installation to show the visiting official, the college psychology class, or the ladies and gentlemen from the civic organization. If the mental hospital could not display concrete, attention-arresting sights like newborns in a nursery, enormous radiotherapeutic machinery, or facilities for cardiac catheterization, at least it could show off some gleaming hydrotherapy gadgets. If the turnover rate was unimpressive, and re-admission rates too high to display on a graph, at least popular interest could be focused on the baths. At a time when "treatment" was only a euphemism, the hydro unit was the Superintendent's pride. It was the main visible evidence of any kind of therapy.

But hydrotherapy seems to have passed the peak of its prestige. The newest hospitals have smaller units, or none at all. As hydrotherapists retire, they are not replaced. Rosters of patients in baths get smaller. More and more public hospitals rip out existing hydro installations. They find other use for the space. Some hydrotherapists, re-assigned to ward duties (or sometimes to hospital fire departments) mourn their lost glory. Some write indignant letters to newspapers about near-sighted officials who are scrapping hydrotherapy. They predict that pharmaceuticals and shock are fads, here today and gone tomorrow. Hydrotherapy, they write, has two millennia of cures to its credit. Nothing stimulates like cold water; nothing is so tranquilizing as a warm tub. They warn that administrators will be sorry if they irretrievably tear out tubs and pipes.

But their voices remain unheeded. Hydrotherapy, it seems, is a dead duck.

A NEW TOOL IN PSYCHIATRIC EDUCATION

First Report from Nebraska Psychiatric Institute on Teaching Methods with Closed-circuit Television

By CECIL WITTSON, M.D., Director and RON DUTTON, A.M.T., Mental Health Educator
Nebraska Psychiatric Institute, Omaha, Nebraska

ANTICIPATING THE RAPID development of closed circuit television as a teaching and training tool, the Nebraska Psychiatric Institute was designed and built with camera-cable conduits and a complete television system with sound. (See MENTAL HOSPITALS, September, 1955.)

After a year of experimentation with television teaching in psychiatry and related disciplines, working out inexpensive production techniques and trying a variety of program formats, we are ready to make our first report on closed-circuit television as a teaching tool in a psychiatric training hospital.

Our television system cost approximately $18,000, and was designed and manufactured by the General Precision Laboratory, Inc. of Pleasantville, New York. The architectural design to accommodate the system was by John Latenser Jr., of Omaha, Nebraska.

The pictures show a typical teaching production step-by-step, and some of the necessary equipment. We have three vidicon cameras, three 17-inch monitor receivers in the control room, and a receiver-projector in the auditorium which projects the television image on a six-by-seven foot screen.

Three custom-built camera carts carry the sound system pre-amp, cables, lenses, headphones, electronics control apparatus, and an 8-inch picture monitoring set.

The three cameras can be operated as far as forty feet away from any of the six cable outlets on the conduits built into the Institute. Several conduits terminate in special small closets (camera-ports), which observe interview or treatment rooms through a one-way mirror. In order to get a satisfactory picture, the scene being photographed through such a mirror must be well lighted. Rooms connected to camera-ports have ceiling microphones and adjustable ceiling lights.

Special Technicians Employed

The television equipment is easy to operate. However, with a number of other audio-visual aids (including a two-way telephonic communications network to other state institutions), we found it expedient to engage a full-time electronics technician. In addition, we have the part-time services of a co-ordinator of television pro-

Left: From camera port next to play therapy room, medical electronics consultant Harold Beenken switches on monitor set on camera cart. Camera is already "live", shooting scene shown on left monitor set in control room (small picture below). Headphones keep Beenken in touch with control room.

Center: Television camera sees this scene through one-way mirror just after psychologist Gerald Patterson, Ph.D., and a boy patient have entered. Their conversation is picked up by a ceiling microphone. They cannot see the camera or Mr. Beenken. Ceiling lights are brighter than normal and patient is not aware of television operation. Boy was told earlier, however, that part of session is to be photographed.

gramming, and a consultant in medical electronics.

We have encouraged our faculty to write shooting scripts in a standardized "television-documentary" style, even though many programs involve patients and a large proportion of ad-lib dialogue. The faculty is allowed time for participating effectively in the television teaching. Writing scripts in a regular television format encourages the faculty to use "visual" material and thereby take full advantage of the unique impact of television.

We are trying to use television for teaching situations that cannot be handled as well by any other method. Television is an advance in terms of the numbers of students that can be taught at once. It seems to be an improvement also in terms of the effective teaching of some subject-matter. For example, a close-up of a patient's face during an interview can teach some things better than any lecture.

Policy Criteria Evaluated

Before a program is scheduled for production, it must meet two policy criteria. First, has the subject-matter a visual meaning, or can the student learn it as well by hearing it, or hearing about it? Second, can the material be televised economically, and in a reasonable amount of preparation and rehearsal time?

We have found that the best way to save time is to produce from a regular shooting script that indicates clearly what the teacher wants. The television personnel have written a script-writing and production manual to guide the faculty and staff in using the medium. Most programs rehearse at least the beginning of each scene, in order, with live cameras, props, visual aids, lighting, titles, music, and narration.

We have used our television system in three ways: (1) as an aid to the nurses in maximum-security areas; (2) to show professional visitors the facilities of the Institute; (3) to improve classroom teaching.

Two maximum-security rooms have a special, glassed enclosure high in one corner. A camera there with a wide-angle lens takes in very nearly the whole room. Its picture is received in a nearby nursing station. By watching the monitor set, a nurse can special the patient without making constant walks past his door.

David D. Parrish, M.D., narrates from shooting script of "A Mind Grows Old." "Title card" suggests headache. Below: Van Johnson, electronics technician, watches three 17" monitor sets; he hears through speaker and/or headphones. Screens show (L to R) play-therapy room; opening title (model of the Medical Center); "headache" title card. Johnson can cut off narration microphone and background music played during titles and "bring in" sound and picture from play-therapy room.

Classroom Education Main Purpose

By using television, we can show professional guests certain patient areas without disrupting the treatment program. Television cameras operate with normal lighting (as little as five foot-candles) when certain controls in the electronics mechanism are correctly adjusted. For an image of high quality, studio-type lighting is needed, but not studio brightness. Relatively low-wattage flood- and spotlights are sufficient.

The most significant use of television here has been as a tool in classroom education. The Institute, as a joint facility of the State Board of Control and the University of Nebraska College of Medicine, instructed 1018 students during this academic year, in psychiatry, psychology, psychiatric social work, occupational therapy, undergraduate and graduate psychiatric nursing, and related disciplines. The auditorium seats 176 students with a perfect view of the six-by-seven foot screen, and can accommodate more.

The efficiency of television teaching can be demonstrated with just one example. Training usually includes watching and hearing therapists conduct patient interviews. The customary method is to crowd from three to six students in back of a one-way mirror. Although we have seventeen one-way mirror installations with

sound pick-up, only a small number of students can learn this way. By televising the interview, using live sound and close-ups of faces, nearly 200 students can learn simultaneously —and see better. Further, a narrator either in the control room or on the auditorium stage can comment as the interview proceeds, and visual aids can be introduced at appropriate moments.

We have started exploring the possibilities of supplementing regular lectures with dramatic sequences, intended less to illustrate the material than to impress it on the students with great emotional impact. Powerful television drama can be created on a patient's traumatic experiences, past interpersonal battles, or even hallucinations.

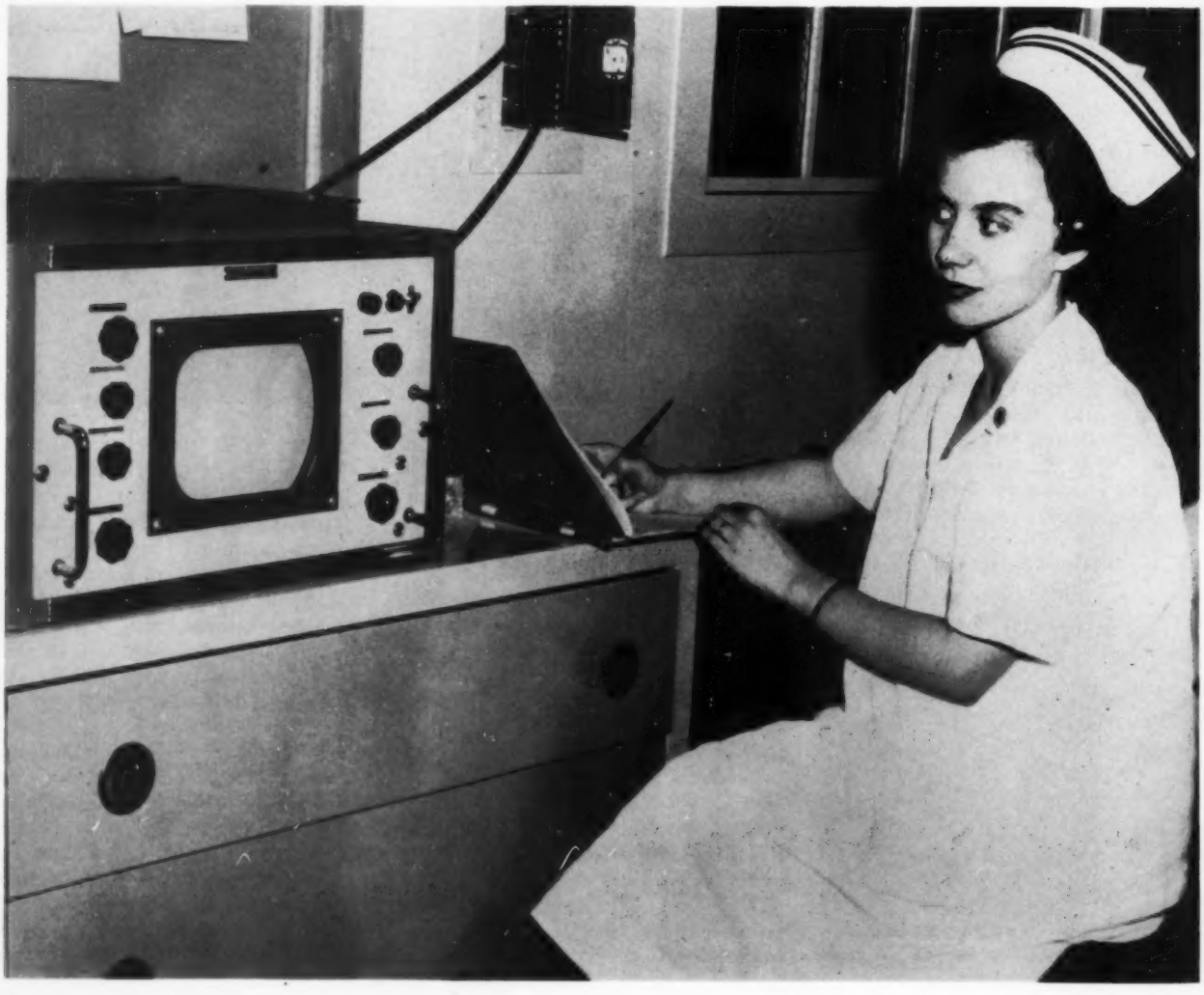
During the coming academic year, we plan to do some control-group experiments to get basic data about the effectiveness of teaching psychiatric material by television, as compared to older methods.

In the near future, our television system will be extended to the Basic Sciences Building of the University of Nebraska Medical School, and we anticipate expansion to the associated state hospitals and to certain departments of the University of Nebraska, which is sixty miles away in Lincoln. We are convinced that television is a worthwhile tool.

This first year of experimentation has shown us that closed-circuit television is technically very satisfactory, and that effective teaching programs can be produced at little expense. Our electronics personnel have encountered no serious technical problems with the equipment.

The next step for us as psychiatric educators, while continuing our experiments with teaching techniques and program formats, is to evaluate the learning experiences of our students. Their response thus far indicates that our efforts have been helpful to them. We feel certain that closed-circuit television is technically ready to be a major tool in professional training for psychiatrists and people in related disciplines, and that its audio-visual impact can make our instruction more efficient, thorough, and effective.

Closed circuit television enables nurse to chart patient activity by watching special monitor screen at nursing station. Built-in camera, out of reach of patients, covers nearly all the ward.



DEPARTMENTS

New Building Improves Kitchen Operations

Since the completion of a Utility Building, which contains warehouses, cold storage, and dining room facilities, we have been able to increase the efficiency and quality of meals to a great extent at State Hospital South, Blackfoot, Idaho. The dining rooms for patients and employees are light, airy and easy to keep clean. The kitchen, which is one of the most modern in this area, is well equipped and efficiently operated. The greater portion of the kitchen work, except actual cooking, is done by patients under the supervision of the head chef and his staff. There are about 150 patients working in the kitchen besides 16 employees. At the present time they are serving approximately 3,000 meals daily.

Also under the supervision of the kitchen is the cannery, which puts up some 30,000 to 40,000 gallons of fruit, preserves, etc., to be used during the winter months. Besides regular routine tasks of the kitchen, the baking department furnishes all bakery goods for patient and employee dining rooms.

Occasionally banquets are held in the employees' dining room by outside organizations and groups. These banquets are self-supporting and any profit from them is placed in the patients' recreational fund.

V. V. McLAUGHLIN
Administrative Assistant

Mental Hygiene Society Reassures Relatives

At the admissions office of each of Maryland's four mental hospitals the accompanying relative is given a letter from the president of the state mental hygiene society. Its message begins:

"Because Maryland is a small and friendly state, the Mental Hygiene Society can address you as neighbor even though we don't know where your home is, or even your name. What we do know is that the day you receive this letter you are having a member of your family admitted to a state mental hospital. We believe that on such a day it may cheer you to know that there is an agency in your state devoted to helping people understand the problems of the mentally ill."

The letter goes on to urge the family to cooperate with the hospital staff, and it offers a free copy of *When Mental Illness Strikes Your Family* and further information about the society.

GERTRUDE L. NILSSON, Exec. Dir.
Mental Hygiene Society of Md.

State School Devises TBC Register Cards

Polk (Pa.) State School has devised tuberculosis register cards to prevent a patient from being lost sight of once he is diagnosed as tuberculous.

A card is made out on a patient when he is first found to have TBC, usually in a semi-annual chest X-ray, and filed as either minimal, active, convalescent, or general population.

Cards list patient's name, county, number, admission date, building, sex, mentality, and condition (destructive, tractable, school, etc.). Ample space is allowed for interpretation along with date and placement.

The cards, which have been adopted by several Pennsylvania institutions, are also useful in answering inquiries from county TBC services about the number of patients from various counties. We feel that the cards will help in ascertaining the whereabouts of previously infected patients and in getting arrested patients back to the general patient population.

GALE H. WALKER, M.D.
Superintendent

Hospital Staff Attempt Public Education

A mental health education program has recently been inagurated in Minnesota's state mental hospitals, under the direction of a newly-appointed mental health educator. According to Mrs. Nancy Kjenaas, who is charged with developing this program for the Department of Public Welfare, the broad objective is to further in every way possible public understanding of mental health and mental illness.

"We can achieve our goal only by working with all available resources within the voluntary agencies as well as the official agencies concerned with problems of mental health," says Mrs. Kjenaas

As the initial step, superintendents of seven of the state's mental hospitals and the three institutions for the mentally retarded have appointed one or more staff members to a public education committee. It will be the function of these groups to plan various ways of bringing information to the public about the hospitals, about the prevention of mental illness and the rehabilitation of the mentally ill.

Other staff members will assist in planning and executing special projects, particularly filling requests for speeches and other special programs for schools and community groups of all kinds.

The committees are of varying composition and are organized along somewhat different lines in each institution. Usually committee members are staff members who in the normal course of their work have the most frequent contact outside the institution. Most commonly represented are volunteer coordinators, chaplains, psychologists and recreation workers, but the committees include members of 10 different classifications within the institutions and represent a wide range of experience.

Representatives of each of the committees met together for the first time recently in St. Paul to coordinate their plans for the future. The large group will meet once or twice a year, with the mental health educator acting as consultant between meetings.

State School Aids In Aptitude Test Revision

A General Aptitude Test Battery is being given to thirty students in vocational education at the Parsons (Kans.) State Training School. The GATB is made up by the Bureau of Employment Security, U. S. Department of Labor. The test has one man-

ual dexterity section and two written sections in sixteen parts covering arithmetic, form perception, space perception, verbalization and spelling.

"It is our hope," said Dr. H. V. Bair, Superintendent of the Training School, "that the results of this test will help the bureau revise the tests so that they will be more applicable to retarded students."

The tests are being administered by the school's Vocational Education Instructor, under the supervision of Kansas University educators.

Admission Information Sent to all Kentucky Physicians

The Kentucky Department of Mental Health recently sent to all physicians in the state a mailing of information about procedures for admitting patients to the state mental hospitals. Enclosed was a table showing the five types of admission and the advantages and disadvantages of each type; a copy of the medical certification form, which was revised earlier this year for the benefit of admitting physicians; and a copy of "The Hospital, the Patient and You", a booklet the department published as a guide for relatives and other interested persons.

The covering letter from Dr. Frank M. Gaines, Commissioner of Mental Health, explained that the booklet was being sent in the hope that it might "someday help some patient of yours obtain treatment at one of our hospitals early enough that our treatment procedures will give him the greatest benefit. So few people know what to expect of the State Hospitals that they delay until the illness has a firm hold," the letter continued, "Perhaps if you could let them read this booklet when hospitalization is advised, their fears will be lessened."

After commenting on the other enclosures, Dr. Gaines concluded by offering the Department's assistance to the doctors with any questions they might have and also in planning follow-up programs for their patients discharged from the state hospitals.

The material was sent to nearly 2500 physicians, using the mailing list of the Kentucky State Medical Association. A similar mailing to all county and circuit judges in the state, with appropriate revisions in the material, is planned in the near future.

News & Notes

400 Hospital Administrators Certified

The Committee on Certification of Mental Hospital Administrators accepted 26 new candidates on their credentials and passed another 8 by examination at their meeting prior to the 8th Mental Hospital Institute, in Denver, Colo. This makes a total of 400 certified mental hospital administrators.

The Committee wishes to draw attention to the fact that the "grandfather clause" expires on the 1st of July, 1958, and thereafter certification will be only by examination.

The next examinations will be held immediately prior to the 1957 A.P.A. Annual Meeting at the Hotel Morrison, Chicago. The dates of the examinations are May 11th and 12th, and the closing date for applications is April 1st.

The Committee voted to hold only one meeting a year in the future, so the next examinations after May 1957 will be in San Francisco in May 1958.

Dr. Cecil L. Wittson, of the Psychiatric Institute, Omaha, Nebraska, was appointed a member of the Committee, replacing Dr. Walter H. Baer, now in private practice in Peoria, Ill.

The Committee now has information regarding approved courses for mental hospitals administrators and the secretary, Dr. Francis J. O'Neill, State Hospital, Central Islip, N. Y., will be happy to send information.

Medical Director's Papers As Supplementary Mailings

Because of the many requests received in the Washington office for copies of the various talks given by Dr. Daniel Blain, it has been decided to make certain speeches available as Supplementary Mailings to the Mental Hospital Service.

Only papers of specific interest to mental hospitals will be included and a few extra copies will be kept in our files in case more are required.

In November, therefore, each subscribing hospital will receive as its Supplementary Mailing a copy of the paper read by Dr. Blain at the American Hospital Association Annual Meeting on September 19, 1956.

Loan Library Additions Now Available

Please quote name and number of book, and enclose 10¢ for each one pound volume and 14¢ for each two pound volume to cover postage and handling.

O.T., R.T., ADJUNCTIVE THERAPIES

8B Recreation Department Manual (Southern Wisconsin Colony & Training School, Union Grove, Wisconsin) 1 lb.

MISCELLANEOUS

17E The Hospital and Medical Facilities Construction Program, under the Title VI of the Public Health Service Act—Semiannual Analysis of Projects Approved for Federal Aid, as of June 30, 1956 1 lb.

18E Revised Master Menu Manual (Prepared by Louis A. Luker, Food Administrator, Department of Public Welfare, Illinois) 4 lbs.

People & Places

Mr. Arthur Snider, Chicago Daily News science editor, well-known to psychiatrists, spoke on the importance of mental health to the press and the public. Occasion was the first meeting of Four County Social Guidance Conference in Southern Wisconsin . . . **Mr. Clarkson Hill,** Business Manager at Institute of Living, Conn. and **Mr. Joseph Prekup,** Assistant Director of McLean Hospital, Mass. were made members of the American College of Hospital Administrators at the Convocation in Chicago . . . **Dr. Daniel Blain,** A.P.A. Medical Director, spoke on "The Unique Position of the Physician in our Society" at the Seventh Annual North Shore Health Resort Lecture Series . . . **Dr. Frank R. Henne** has taken the post of Director of Newark State School . . . He succeeds **Dr. Isaac N. Wolfson** who was recently appointed senior director of Letchworth Village, N. Y. . . . Dr. Wolfson succeeded **Dr. Harry C. Storrs** who recently retired . . . **Dr. George W. Kleinsmidt** has taken the position of Clinical Director and Assistant Superintendent at Eastern State Hospital, Vinita, Okla.

Future Institute Plans Being Made Now

The Ninth Mental Hospital Institute will be held in the Hotel Cleveland, Cleveland, Ohio, from September 30th through October 4th, 1957. The Tenth is planned for the third week in October, 1958, (20th through 23rd) to be held at the Hotel Muehleback, Kansas City, Missouri.

Cities named for future Institutes include Omaha, Nebraska; Rochester or Buffalo, New York State; Salt Lake City, Utah. Dr. Winfred Overholser, Chief Consultant to the Mental Hospital Service is already writing to local psychiatrists about the most satisfactory accommodations.

Arrangements made several years in advance are becoming increasingly necessary because Convention Bureaus inform us that hotels are now booking large meetings as much as five years ahead. Only in this manner can we hope to have satisfactory hotel accommodations in the future.

Fort Lyon VAH Employees Share Award Honors

VA Photo by David M. Houston, Fort Lyon

DR. J. F. CASEY, Chief of Psychiatry & Neurology, of the Veterans Administration, and Dr. Howard P. Morgan, Manager of Fort Lyon VA Hospital, hold the 1956 Mental Hospital Service Achievement Award. Surrounding them are some of the staff members from the hospital who drove to Denver to see the presentation. From left to right: Dr. Lee Gurel, Chief Psychologist; Mrs. M. Morgan, Chief Nurse; Mr. Joe D. Sutton, Asst. Manager; Dr. Casey and Dr. Morgan; Chaplain Paul F. Erickson and Mr. James C. Hickey, Chief, Special Services.

VA Gives Cash Award

Just after Dr. Morgan received the Achievement Award from A.P.A. Medical Director Daniel Blain, Dr. Casey presented him with the VA Group Performance Award to honor the Fort Lyon employees for their part in bringing about "outstanding improvement in the care and treatment of patients." This award, in the amount of $4,360—the largest cash award ever made in the VA—was to be distributed equally among the 436 employees of the hospital, in all positions, who had been employed there at least six months as of May 2, 1956. As a memento of this award, Dr. Morgan was given a Certificate of Commendation from the Veterans Administration.

Mental Hospital Service Honored by American Red Cross

VA Photo by David M. Houston, Fort Lyon

The A.P.A. Mental Hospital Service received recognition this year A.P.A. President Francis J. Braceland, M.D. received a certificate for the Service from Mr. Samuel F. Downer, *(facing camera)* a member of the National Board of Governors of the American Red Cross. The certificate, given on the occasion of the 75th Anniversary of the Red Cross, extended appreciation for the "devoted support of and participation in the humanitarian work of the Red Cross." Mr. Downer said that his organization hoped to have the continuing professional support of the A.P.A. to guide the 3,700 chapters of the Red Cross. The Red Cross last year supplied 4,700 volunteers every months in 151 state mental hospitals.

Social Implications of Chemotherapy

By HARRIET MacLAURIN

Director of Education, Social Service Department
Cleveland State Hospital, Ohio

CLEVELAND STATE HOSPITAL has been using chemotherapy since the fall of 1954. During this period the ataractic drugs have been given to about fifteen hundred patients, many of whom are now on convalescent leave or have been discharged from the hospital rolls. Patients who leave the hospital under medication or who are placed on medication after release, return regularly to out-patient clinic where they are seen by a psychiatrist for evaluation and regulation of the drug, by the psychiatric social worker for interview, and by the laboratory for tests when indicated.

The psychiatric social workers in the clinics have observed that the reactions of patients and their relatives to the use of the chemotherapies fall into certain groups. There is no one reaction, they find, but a constellation of reactions. The following observations are somewhat tentative and much needs to be done in the way of research before definitive conclusions can be drawn.

While there is no universal reaction to the drugs among our patients and their families, there is one almost universal effect. Most of the patients experience as sort of generalized slowing down, what they themselves call 'fogginess." They seem to require a great deal of rest and are able to sleep at any time. They talk dreamily of getting a job but if the caseworker becomes specific, such as offering a referral to an employment service, the patient replies that he is not ready for work now, that he needs more rest.

Families' Reactions Vary

On the part of the families, if they need to place the patient in the position of a child who must be cared for, his inability to mobilize himself plays into their needs and they foster his dependence. Furthermore, many patients who are still quite psychotic are able to live at home because they present no problem in management. Rather than keeping the environment in an uproar as might have been the case had they been released before the days of chemotherapy, they do not require constant supervision and hence the various family members can carry on their usual activities.

A family's need to have the patient be a child was exemplified by the Green family. The son Arthur, now 38, has been hospitalized off and on for fifteen years with a diagnosis of chronic undifferentiated schizophrenia. The caseworker was called to the home to settle a family crisis. The parents were quarreling vigorously about the way the patient should regulate his life. The mother complained that he watched television until 1:00 a.m., slept until 2:00 or 3:00 the following afternoon, got up and ate, then went back to watching television. This was absolutely no good, she said. Why? Because he did not get enough to eat. He should get up in the morning, eat a heavy breakfast, *then* go back to bed.

The father objected violently to this point of view. The boy, he said, should do some work around the house; only in that way could he build up an appetite. When the patient, who had remained bland throughout this altercation, offered to cut the lawn, his mother hastily vetoed this suggestion on the grounds that this work was too hard for him.

With another group of relatives we find just the opposite reaction. These relatives say to the caseworker, "You said he was well enough to come home. He's not well at all. All he wants to do is sit around or sleep all day." These relatives have never either understood or accepted the patient's illness and have always thought of him in terms of a behavior problem. Now they see him as over his gross symptons and they say, "He's an able-bodied man of 30. Why doesn't he get a job?" They pressure the patient, who responds by pleading that he needs rest. "Rest? You've been resting for two months. Get out of the house and go to work!" Working members, especially, of such families tend to resent the patient's non-productive leisure.

Length of Hospitalization a Factor

The drugs are, of course, reaching many patients who have been hospitalized for 15 or 20 years during which time various of the organic therapies were tried with little if any lasting benefit. The families had long since lost hope and had built a life for themselves which did not include the patient. To have someone from Social Service approach them with the information that the patient is ready to go home can be terribly threatening. They may develop all sorts of symptoms such as headaches and gastrointestinal upsets. The patient himself is sometimes fearful and reluctant to go—the hospital has become home.

With a different kind of family, a factor operating with the group which has been hospitalized for a long time is the feeling that the drug is the last hope. If this fails there is nothing. They exhibit considerable anxiety over every little change in the patient's condition and scrutinize the minutiae of his ups and downs like a broker watching a ticker tape. If his medication is changed they ask anxiously, "Does it mean he is better? Worse?" This kind of constant, hawk-like surveillance at home is apt to put the patient under a degree of tension —more, perhaps, than he would have been able to tolerate in the pre-drug days.

We often encounter great resistance on the part of the patient to the necessity to take medication, with its implication that he is a sick person. Some have a fear of the drug being a

narcotic like heroin. They ask anxiously if they will become addicts. Will they have to take increasingly larger doses? To remain on it for the rest of their lives? One former narcotics addict stopped taking chlorpromazine for several days to see if he could break that habit, too. He was gratified to find he was more alert but became so tense he could not handle it, and went back on the drug of his own accord.

Sometimes the patients see it as a plot to keep them doped or even poisoned. One patient was convinced it was an aphrodisiac, part of a scheme by her husband to induce her to run away with another man so he could be rid of her. She refused to take "those monkey glands." Another patient said he resented having to take the drug because "it masks my symptoms so I can't learn to handle them."

There is a tendency to blame the drug for all kinds of unrelated physical reactions and this seems to play into the picture of the neurotic which, as we know, is often presented by the schizophrenic in remission.

Payment Arouses Anxieties

The question of payment for the drug comes up repeatedly. The cost of the usual dosage we give our out-patients is $4.35 and $6.00 a month for chlorpromazine and reserpine, respectively. Since $4.35 a month is not really a sizable item in the budget of most families, we must look to other, perhaps deeper causes for the extreme resistance shown by so many families to paying for the drug. For one thing, there is the attitude that while it's taken for granted that you have your family physician's prescription filled without question, the patient's present condition is the fault of a remote something called "the State." If you agree to pay for the drug, you are acknowledging some responsibility in the patient's illness. If you refuse to pay, you are denying your part in it.

Some relatives who have had experience over the years with the patient's recurrent episodes and consequent series of hospitalizations distrust his ability to stay well with or without the drug. They ask, "Why should I put out that money when he will be back in the hospital in six months anyway?" Others seem to feel a need to punish the hospital. As one mother expressed it, "You had her all those years and didn't do anything for her. Now you can just furnish this drug and we will see if she can make it on the outside."

On the other hand, some relatives find great reassurance in a pill you can pay for in a drug store. A pill treats tangible things such as headaches and thus the chemotherapies can dispel some of that fear of the unknown which is associated with mental illness. On the whole, the working patients seem to find satisfaction in being able to pay for the drug. One said it made him feel different about mental illness, that it was more like any other illness because he could buy medicine.

One final observation leads us into the realm of speculation. It has been noticed that despite the lethargy-inducing effect of the drugs, the working patients find that they are adequately alert during working hours when they have to concentrate and focus their energies on a specific task. They themselves see that the effects of the drug can be resisted, that they can "will it away." It is only when they are relaxed, such as when watching television, that the drug seems to take over.

This causes us to speculate as to the extent to which motivation enters into the picture. If some patients, under certain demands such as those imposed by a job, are able to function adequately, why are others not able to do so even though in their particular environment there are plenty of things to be done? In the latter group would be included those who remain at home but who contribute little or nothing to the management of the household. To what extent does the effect of the drug play into their dependency needs?

Much research needs to be done on questions such as these. But if it is found that there is a correlation between motivation and the ability to resist the slowing down process induced by the drugs, then one of the chief problems for those who work in mental hospitals may very well turn out to be an old problem in a somewhat new guise: how can we help the patient to mobilize himself sufficiently so that he can withstand the effect of the drug and function on a more adequate level?

THE PATIENT DAY BY DAY

"Acting" Fine Activity for Chronic Regressed Patients

Occupational therapists at the Veterans Administration Hospital in Waco, Texas continually try to motivate chronic regressed male patients by providing new and unusual activities. Since receiving drug therapy these patients have become much more amenable to treatment and it is now possible to help them relate to others by providing projects which encourage group participation.

In one of our clinics where these patients are treated, simple patient performances have been used very successfully. Some of the ideas used have been a Columbus Day play adapted to the abilities of the patients, a May Fete with marches instead of dances used to entertain the O. T. student queen and a Circus Carnival with typical circus characters. Patients on the ward building and various hospital personnel attend by invitation. The clinic rhythm band is always used as part of the program and provides very regressed patients a chance to participate.

A patient stands inside the "tall man" whose upper body is a frame-work made of crating with a papier-maché head.

The Circus Carnival took place recently and was successful in every way.

It provided many small group projects within the activity suitable for the varied abilities and interests of thirty different patients. Tracing and cutting out the letters used on the back drop, cutting out the many colored pennants which decorated the clinic, making the invitations, building the platforms and props, painting the back drops, repairing the band instruments, etc. were accomplished by groups of patients working together. Simple costumes were made or assembled with the help of volunteers. The actual performers, many of whom were still very regressed, seemed to gain great satisfaction from their accomplishments.

Directing such an activity has been found to be a most worthwhile clinical experience for our O. T. students. It provides excellent opportunities to develop relationships with patients and to observe their progress as these patients relate within the group. Students, under the direction of an experienced therapist, plan and direct these projects. They also write a paper evaluating what they themselves gained from the experience, as well as the treatment it provided the patients participating.

LOUISE McMILLEN, O.T.R.
Chief, Occupational Therapy Section

Theater Seats Bought out of "Found Money"

Many hospitals receive special gifts of money with no strings attached other than "we would like you to use this donation for the welfare of your patients." Of course there are many uses for this type of donation but the New Jersey State Hospital at Trenton has, for the past two years, used this type of gifts in a unique way.

At Lambertville, New Jersey, about fifteen miles from Trenton is a picturesque spot overlooking the historical Delaware river which is known as "Music Mountain." The name is all that it implies because throughout the summer and early fall a tent is pitched from which can be heard the strains of a Strauss Waltz or a Cole Porter tune. It is to this "Theatre in the Round" known as the Music Circus that the Trenton Hospital sends approximately thirty patients to a Saturday matinee performance of each of its listed shows. This year they enjoyed such productions as "The King and I," "Plain and Fancy," "Student Prince," "Annie, Get Your Gun" and "Teahouse of the August Moon." The patients make the trip in a chartered bus.

In addition to attending the show the patients are given a picnic supper. Substantial box suppers and thermos containers of iced tea and lemonade go along on the bus and at the conclusion of the performance everybody gathers on the hillside for a picnic instead of returning to the hospital for the evening meal.

Dr. Harold S. Magee, Hospital Superintendent, has stated that it is one of the finer projects undertaken by the hospital and its effect as a morale booster is of inestimable value.

The cooperation of the Music Circus officials has played a most important part in the success of these show trips. Tickets are made available at special prices and every effort is made to the end that the group is not identified as "patients." An equal number of men and women patients attend, and they are accompanied by two men and two women employees. While they are of necessity seated in a group, each patient has his or her own ticket and is personally ushered to a seat. Before leaving the hospital each patient is given a small sum of money to spend as he sees fit for refreshments during intermission.

Elderly Patients Discuss Varied and Lively Topics

Discussion groups dealing with matters of general and current interest have proved to be an excellent activity for elderly women patients on the ward level at the Moose Lake (Minn.) State Hospital. The group was originally organized by a charge aide, but one patient who demonstrated leadership ability assists with the project and conducts the hour-long session each week.

Each session opens with a Bible

verse, a prayer and an "old favorite" hymn. Patients are assigned specific topics to discuss and spend hours in the hospital library looking up information. Old magazines are collected and pictures which help illustrate a point are cut out and passed around.

Topics so far have included election procedures; holidays, their origin and history; and the history and life of the different States. This latter topic is always discussed very thoroughly.

The leader's own enthusiasm has sparked the rest of the group, which has increased from the original 20 patients to about 60 every week.

H. HUTCHINSON, M. D.
Superintendent.
Moose Lake
State Hospital, Minn.

Retarded Children Undertake "Self-Government"

An approach to some degree of pupil self-government has had a successful beginning at the Enid (Okla.) State School where both an overall Pupil Council and individual "Cottage Committees" are in operation.

The pupils have responded enthusiastically to the opportunity. Although inevitably many of the first requests were personal, subsequent meetings produced increasingly constructive suggestions.

A special Parents' Day parade of floats from the various cottages to duplicate the area's annual Cherokee Strip celebration was an idea that was quickly adopted.

Another request was for comprehensive tours of the institution facilities "so we can see what the others do and where they live".

"Our aim is to give our pupils a more active role in campus life, to encourage them to participate more in cottage discipline, and to give ourselves greater insight into their needs," comments Ira Goldberg, school psychologist and advisor to the program.

The Pupil Council consists of three officers plus a representative from each of 15 boys' and girls' cottages. The Cottage Committees are groups of brighter, older pupils selected to assist the housemother in cottage operations.

ANNA T. SCRUGGS,
Superintendent

Maximum Security Patients Help Conduct Classes

More than 200 patients ranging in age from 16 to 79 attend classes at Atascadero (Calif.) State Hospital. Their previous education varies from near illiteracy to just short of college degrees. There is only one state-employed teacher, but twenty patients on industrial assignment do the rest of the instructing, most of which is given individually.

Most of the patient-teachers are college trained. They learn to share their skills, knowledge, and personality. While they are helping others, they forget themselves; their personalities unfold and develop. Many teachers feel that they are benefiting more from the classes than their students are.

There are 333 classroom hours a week and considerable homework on the wards. Regular elementary subjects are taught continuously, and other courses are given as the interest arises. Some of the current ones are ancient history, science, bookkeeping, advanced English, Spanish, French, and shorthand. Almost all attendance is voluntary.

Handling Charge to be Made for M.H.S. Films

Starting on January 1st, a handling charge of $1.65 will be made for *each film* borrowed from the Mental Hospital Service Film Library. We regret that this is necessary, but because of the enormous increase in the number of bookings, our annual bill for handling now amounts to well over $2,000—money which ought to be spent on buying new titles or replacing worn prints in order to speed up the service.

The $1.65 represents the exact handling charge made to us by the agency which handles our bookings, repairs and replacements.

New booking forms will be sent out in December, and beginning January 1st, only these new requisition forms will be honored.

Integration of a Research Division in a General Mental Hospital

By L. H. RUDY, M. D., Superintendent
Galesburg State Research Hospital, Illinois

WITH THE INCREASED public awareness of the problem of mental illness, a demand has arisen for research to attack this problem on all fronts—the basic neurophysiologic, the clinico-dynamic, and the sociologic. Research into mental illness has become so complex and so dependent upon the other disciplines that the lone worker, the individualist, is an anachronism. Today effective research depends upon the talents of highly trained scientists united under coordinated leadership supplying continuity of purpose and goal direction.

As a general hospital is a focal point for medical research, so the progressive mental hospital is becoming the center for expanding research within the basic and clinical spheres. As large amounts of money become available it is the responsibility of the research center to use the funds in a highly productive manner and always in correlation within the general mental hospital structure. Along with the stimulus that a hospital staff receives from research grants come added problems. Research, apart from the humanistic value, is big business and as such requires skillful administration. At Galesburg we believe that we have come a long way in learning to make a research program mutually rewarding to researcher and clinician.

Superintendent Supervises Research Program

The over-all responsibility for the operation of the hospital, including the research division, rests with the hospital superintendent, who coordinates laboratory and clinical research with care of the patients. We have found that the most effective organization is one in which the superintendent, who should be a psychiatrist as well as administrator, has general supervision of the research program. The position of research director has the same status in the hospital organization as that of clinical director; authority stems from the superintendent and the research director assumes the responsibility for his own division, which in our hospital consists of forty-five employees. The superintendent is the medium through which the clinical director and the research director integrate the programs of patient care, staff training and clinical research. The fact that the superintendent is a psychiatrist has been of value in collaborative research and in providing him with a better knowledge and understanding of the scope of the investigative activities. Because of this, the superintendent has been able to participate in the research program and share the frustrations and rewards of active research with new and different insights into the complex nature of multi-disciplinary investigation. It is imperative that the hospital administrator integrate the desired goals and be empathic with the aim of the research program; daily conferences with the research director are essential in order to further knowledge of the many problems arising from a flexible research activity.

There appears to be a growing tendency to name research centers after great men of science or the benefactors of laboratories. We believe that there are other ways of immortalizing the contributions of these scientists and patrons. Setting up separate divisions according to proper names creates confusion, and tends to undermine the integrated research program by setting up boundaries between clinician and researcher. Such a procedure creates levels of status and often times reduplicates personnel and equipment. For example, originally the Galesburg State Research Hospital developed its own library as did the Thudichum Research division, (named for John William Lewis Thudichum, founder of brain chemistry), but neither had adequate staffing or material. By combining the libraries and establishing a joint library committee it was possible to increase the number of books and periodicals and to obtain the full-time services of a librarian. Thus both hospital and research division benefitted.

Importance of "Hard" Money

It is imperative that the research director have a working knowledge of the funds available and that a realistic operational budget be submitted and maintained. Within this budget allowances should be made for the indirect expenses, the overhead. Dr. Robert Cutler, Chairman of the Board of Trustees of Peter Bent Brigham Hospital, in a provocative article in the *Journal of the American Medical Association**, refers to overhead money as the "hard money" and as the crucial nature of the problem of research. He makes it abundantly clear that institutions are finding it impossible to accept research programs unless the programs provide for an equitable share of "hard money". At Galesburg, the research functions are operated within a special budget termed the Mental Health Fund which takes into account the necessary overhead with an attempt at prorating. The Illinois Mental Health Fund is derived from the payments of the relatives of the mentally ill, and by law it may be expended only on research and training. For example, this fund financed the following additions to the payroll: electricians and

**Cutler, R.: "Let's Save the Goose that Lays the Golden Egg". Jnl. A. M. A. 160:282 - 284: 1956*

carpenters required because of the complex mechanical systems within the specialized laboratory; the additional nurses and psychiatric aides required when research is extended from the laboratory into the wards.

Another important aspect of administration in bringing together the clinical and research division is the maintenance of accurate records and the employment of modern accounting practices. Each research project in the Galesburg State Research Hospital is cost accounted. It is only by this method that research activities can be operated within their allowances and their future budgets accurately gauged.

Research, in order to be effective, must be a collaborative effort under capable direction. At Galesburg, the research director has both authority and responsibility to administer the program. It is his responsibility to select and train his personnel and to guide them in their work. It is the responsibility of the hospital administrator to provide the climate conducive to top-level research and to lend stimulus and implementation to the program.

Researchers Get Equal Benefits

The research personnel should be full-time and free from other duties and responsibilities. Consistent with this approach, we have freed the research director from onerous administrative tasks by providing him with an administrative assistant to deal with such matters as budget, equipment, and personnel.

It is fundamental that the laboratory scientists be afforded the same benefits that the clinical staff of the hospital receive. They should, for instance, receive the same consideration regarding maintenance consistent with the hospital regulations. The research person should not abuse these privileges and must adhere to the clearly defined working conditions. If these practices are adhered to, the hospital community will be a much happier one.

It is important for a researcher to be in communication with other scientists. This is partly accomplished by letters and articles, but it is also essential that he be given time and travel expenses to attend special meetings of his own discipline. At Galesburg, the research division has its own travel fund to insure proper representation to the major meetings. The requests are screened at the hospital and ultimately approved by the Department of Public Welfare which operates the mental hospital service in Illinois. Priority is given to those individuals presenting papers or exhibits. When a hospital is new or somewhat removed from a center with greater library resources, provisions must be made for the research investigator to utilize the university libraries. At Galesburg, the principal research personnel are allowed travel time and expenses for this purpose as the need arises.

Opportunities for Scientific Interchange

Since it is our feeling that the publication of a report or scientific article is the joint responsibility of the hospital and the individual, arrangements are made for providing reprints of articles published by the staff. We feel that it would be unfair to expect the scientists to defray this expense, and arrangements have been made to purchase reprints to fulfill the requests.

It is an added responsibility of the administration to provide for the development and growth of the research staff by presenting seminars and making available the services of highly specialized consultants. At the Galesburg State Research Hospital a well-organized program has been developed and much information has been exchanged between research personnel and consultants of national standing. A structured program is developed a year in advance and definite commitments made to visiting lecturers. The hospital has made effective liaison with the University of Illinois and several meetings have been presented under joint sponsorship; the research director has professorial status at the University.

It has become important for mental hospitals to relate effectively to the community by means of public relations. The press has become vitally concerned with the problem of mental illness and with research in this area. It is important that a public relations officer be designated and that all material be released through his office. The principal investigator should release information only after clearance with the hospital administration. Thus practice consistent with ethical medical standards is insured. This is another area wherein cooperation between administration and the research staff is important.

"Team" Includes the Researcher

The essence of a successful program is reflected by the level of understanding between the research staff and the general hospital staff. A high level of cooperation has been reached by the appointment of a joint research committee which considers the projects of the full-time researcher and lends support to the individual requests of other members of the hospital staff – psychiatrist, physician, clinical psychologist, and nurse.

An even more significant understanding has been developed by the expansion of the team concept to include the researcher. At Galesburg, the therapeutic team comprises the psychiatrist, psychologist, psychiatric social worker, nurse, attendant, volunteer—and research investigator. Only by the total evaluation of the patient in his milieu can systematic and orderly progress be made in both treatment and research. Rapprochement between clinician and researcher in a concerted and combined attack on mental illness is beginning to show progress. With the utilization of the complete psychiatric team, individuals work in a more rewarding and stimulating environment enhanced by better communication, understanding, and new insights.

The problem of ward administration and supervision may often be a source of disagreement. If it is understood, however, that the ultimate responsibility for the care and treatment of patients rests with the assigned physician and that the researcher can act only in a staff or advisory position, the program will be successful. Control of the ward treatment program including medical, psychiatric, nursing, and activity therapies, rests with the physician. All prescriptions must originate with him.

Because of the enhanced interest in the drug treatment of the patients, it is imperative that new treatments be first screened at the animal level and used clinically only after careful consideration of the pharmacologic prop-

erties of these agents. At Galesburg, each new drug is presented before the Illinois Psychiatric Advisory Council* for clearance prior to its clinical use.

Superintendent Must Coordinate Both Programs

The role of the superintendent should be an active one. It is he who promotes the most satisfactory milieu for research; correlates laboratory work with clinical program and patient care; aids the research director in securing personnel and equipment; promotes public relations; effects relationship with the universities and scientific societies and cooperates in securing publication of completed studies. If possible, it is desirable for the superintendent to utilize his professional psychiatric training and experience to implement the clinical activities of the program.

Because of the cooperation and complete understanding between the clinical and research divisions of this hospital, there has been little friction and the goal of harmony and unity has been reached. A firm foundation has been made for the continued expansion of the research and clinical activities under single administration.

**A ten man council appointed by the governor to include the chairmen of the departments of psychiatry of the Chicago area medical schools and directors of psychiatric institutes.*

Some Galesburg Research Projects

The Research Dept. is studying and has reported on the use of reserpine and its mode of action in the human brain. The use of glutamic acid in the aging has been reported on by the biochemical laboratory and a full-scale long-term study on aging is being conducted on the metabolic wards. Other studies include investigation on the blood-brain barrier; cytochemical studies of brain tissues; pharmacological action of drugs on the nervous system; the effects of atropine; and biochemical studies on hereditary cerebellar degeneration. A large proportion of patients are chronic, aged, long-term psychotics with poor prognosis.

Galesburg State Research Hospital

Biochemistry Laboratory

Kjeldahl Apparatus

Research Seminar by Dr. Harold Himwich

No. 6B in a Series on Mental Hospital Administration

CLINICAL PASTORAL TRAINING

By the Rev. Ernest E. Bruder
Coordinator, Chaplain Services Branch
Saint Elizabeths Hospital, Washington, D. C.

CLINICAL PASTORAL TRAINING* seeks to provide a clinically trained religious ministry in mental hospitals and, under competent supervision, to give clergymen a first-hand experience in working with people who have major problems in living. It provides theological students and clergymen with intensive, supervised clinical study of interpersonal relationships, and deals with the resources, methods, and meanings of religion as these are expressed through pastoral care. Clinical pastoral training can be offered on four levels:

I. *Part-time Course for Community Clergymen*: These courses are intended to help the local clergyman in his pastoral ministry, both to the parishioner who is ill and to the patient's family. Such courses offer lectures and seminars on mental illness and its related problems, opportunities for understanding hospital commitment procedures, the treatment of the hospitalized patient, the nature of the religious ministry to patients, and the interrelationship of religion and psychiatry. Special attention is also devoted to the problems involved in helping the family and aiding the patient's return to the community. Courses are conducted one-half day per week for twelve weeks and include lectures, seminars, tours of the hospital, and visits with the patients.

To be accepted for such a course, a participant must be in pastoral work and be interviewed personally by a Chaplain Supervisor with a view toward determining his emotional stability for such study. Arrangements can often be made with a nearby seminary to offer academic credit leading to advanced degrees for such courses, if given under accredited supervision.

II. *The Chaplain Extern*: Men who are accepted for this level of training should have a Bachelor's degree or its equivalent, have completed one full year in a recognized theological seminary, and have been interviewed and recommended for such training by a representative of such a standards-making, accrediting, and certifying body as the Council for Clinical Training, Inc.

Courses for such students may be designed as part of their preparation for the parish ministry and run twelve weeks, full-time, with the student participating in all of the chaplaincy activities. In addition to the content outlined in the part-time course, the student spends more time in learning about the mentally ill person, administrative procedures and problems dealing with the mentally ill, and the pastoral and religious concerns in ministering to them. A major focus is on the dynamics of interpersonal processes, especially as these involve the student in his work with patients.

III. *The Chaplain Intern*: The third level of training is for men who intend to specialize in a mental hospital chaplaincy. At least one full year of supervised experience is required for national accreditation. The course content consists largely of an extension and intensification of the three months' course offered to the Chaplain Extern. In order to qualify for such a course, a candidate must have been ordained, with full college and seminary preparation, have had some parish experience, and have been personally interviewed and recommended for such training by a competent examiner.

IV. *The Chaplain Resident*: The fourth level represents a second full year of specialized training.* Candidates must not only be specializing in an institutional ministry, but desire accreditation as Chaplain Supervisors of clinical pastoral training programs. Such training can be extremely useful to those who intend to teach pastoral theology or related disciplines in theological education, or who wish to specialize in pastoral counseling. The training provides additional clinical experience and understanding to help the candidate interpret the meaning, methodology, and objectives of such a specialized ministry.

Content of Training Programs

The courses consist of lectures on the mentally ill person, on problems in dealing with him, hospital procedures and facilities for treatment; staff conferences; observation of therapies; personal contact with patients (primarily through interviewing as a chaplain, in super-

* *Much interest has been expressed in the function of a Chaplain Supervisor and the levels of clinical pastoral training since Dr. R. Finley Gayle, Jr., addressed the A.P.A. on "Conflict and Cooperation between Religion and Psychiatry," May 1956.*

* *The second year of Chaplain Residency training, as of this writing, is given only at Saint Elizabeths Hospital in Washington, D. C., a part of the United States Department of Health, Education, and Welfare.*

vised social and recreational contacts, and in the worshiping congregation); seminars conducted by the Chaplain Supervisor dealing with the pastoral and religious concerns of a mental hospital ministry, mental illness, and the dynamics of personality development; supplementary reading; and regular personal conferences held individually with each student.

The Chaplain Supervisor

The adequacy of a clinical pastoral training program depends largely upon the training and competence of the Chaplain Supervisor. He should meet the national standards in both personal and professional qualifications.* Seminary education, ordination, and parish experience are not sufficient. Specialized clinical pastoral training is mandatory for such responsibilities. Should it not be possible to obtain a chaplain trained and accredited according to the highest national standards, it is strongly recommended that the hospital continue to rely on local ministerial help for part-time service, and that no fulltime appointments be made until a qualified chaplain supervisor becomes available.

A chaplain qualified to supervise students and clergymen in training is in a position to make a more rewarding contribution to the hospital. Not only must he keep abreast of current trends in religious and psychiatric education, but the program he offers helps enlarge the significance of the hospital's educational program. In this way also there comes to be an interdisciplinary learning and exchange which augurs well for future professional cooperation.

Another contribution of the Chaplain Supervisor to the staff is his ability to discuss with the hospital administration various problems related to religious and psychiatric collaboration, and to advise the superintendent and staff members on religious involvements where patients, relatives, and staff members are concerned. He can serve the superintendent as consultant in such matters as research and development of new ideas, methods, procedures, and techniques related to the chaplaincy program and the relationship between religion and psychiatry, leading to positive recommendations designed to advance, clarify, or fortify the program, religious services to patients, and clinical pastoral training programs. He can also offer informed advice on methods whereby religious understanding and practices can be integrated with other professional services to attain necessary therapeutic goals; contacts with religious professional groups; and the technical soundness and value of religious literature and publications.

Contribution to Hospital Patients

It is recognized that through such programs the trained clergyman comes to be more accepting of himself and hence more accepting of others, especially those who exhibit unusual personality behavior. Reducing the level of personal anxiety to the point where more constructive relations can occur between the pastor and patient can materially aid the patient's return to health. A pastor often symbolizes the stern, forbidding, and condemnatory aspects of the community conscience. With a more accepting attitude he can accelerate the fearful patient's progress toward health.

Such an accepting attitude, developed through training, can influence all that the chaplain does. For example, in his visiting of newly admitted patients, those physically ill, or patients specially referred to him by staff or community members, he can help the patient to accept the fact of illness and hospitalization and to deal realistically with the factors contributing to his illness. The chaplain's attitude will affect his manner of conducting regular and special worship services, his sermons, and group experiences, so that these aid in breaking down the wall of isolation and loneliness so often present.

This attitude is also important in the difficult area of ministry to the critically ill patient and his relatives, in conducting funeral services, in supporting the bereaved.

In some special cases where the patient's background and problems are religiously oriented, the clinically trained chaplain can be called upon to administer psychotherapy to patients of his own faith, as determined by the referring medical officer, and under medical supervision.

Values to the Hospital

The contributions of clinical pastoral training courses to the hospital are varied and many. The clinically trained community clergyman is a more frequent and helpful hospital visitor; is better able to detect signs of incipient mental illness in his parishioners and make appropriate referrals; and is more accepting of psychiatry and its contributions in ameliorating problems in living. Not the least of the values is in gaining an influential and vocal element in the community clergymen who are informed about problems faced by the administrator in attempting to do the best possible therapeutic job for his patients.

Carefully set up programs of clinical pastoral training, under competent and accredited supervision, can be a most effective means for furthering community relations. Through these programs the hospital can make a distinctive contribution to community education, and the result may well effect some of the major goals of an adequate mental health program. In addition, such courses provide the media by which mental hospitals will obtain future chaplain supervisors.

It cannot be overemphasized that the hospitalized patient requires adequately trained and specialized attention from all professional personnel. It is imperative that no official responsibility for dealing with a sick person be given to any professional worker who has not been adequately trained. The chaplain can and must be no exception. It is felt that the standards of the Council for Clinical Training, Inc., requiring as they do one full year of clinical internship before a pastor can be accredited as a hospital chaplain, represent but a minimum period of training.

**Attention is drawn to the A.P.A.* Standards for Hospitals and Clinics, *1956 Edition, which states, "Mental Hospital Chaplains should have special professional training as recommended by the Council for Clinical Training, Inc., and the Mental Hospital Chaplains' Association." (page 46)*

The Lafayette Clinic

Wayne State University, Detroit, Michigan

***Architects:* Eberle M. Smith Associates, Detroit, Michigan**

Since the primary functions of the Lafayette Clinic, in Detroit, Michigan, are research and the training of personnel, only about 50% of the total hospital area is devoted to patient care. The rest of the building consists of service and research laboratories, and an educational wing devoted to a library, an auditorium and large classrooms.

The Institute is one of the first buildings to be erected on a 200-acre slum-clearance area, adjacent to the downtown Detroit Medical Center. It borders a future express highway.

The educational wing, reception area, administrative and business offices, laboratories, doctors' offices and out-patient clinics are on the ground floor. So is the children's wing, which has a private entrance, its own dayroom and dining room, and an adjacent outdoor play area.

Of the 145 beds provided, 20 are for children, 25 for adolescents and the remaining 100 for adults. In addition to the inpatient facilities, there are two outpatient areas—one for adults and one for children.

The plan of the three upper floors, where adults and adolescents will be accommodated, is based on two corridors, with a service core between them. This plan allows the maximum amount of exterior wall space for patients' rooms. It likewise provides ready access to service facilities and utilities. The two elevators make possible "vertical circulation" on a segregated basis—one elevator for medical staff and visitors, and the other for patients, service personnel, food and linens.

Each of the upper floors contains, in addition to the patients' rooms, dining room and kitchen, dayrooms and a visitors' room. The fourth floor will house the more disturbed adult patients. The grouping of the dayrooms and dining rooms in the mid-section of each floor, combined with the double corridor, allows segregated grouping of patients, but permits controlled intermingling for social life and group therapy.

The building itself is of reinforced concrete, utilizing a flat plate and shallow beam construction. This saved building space by reducing floor-to-floor height, but also permitted ease of piping and duct arrangement above the suspended ceiling. The radiant heating system in the ceilings is easily adaptable to air conditioning.

The total cost of site, equipment and building was $3,237,517.

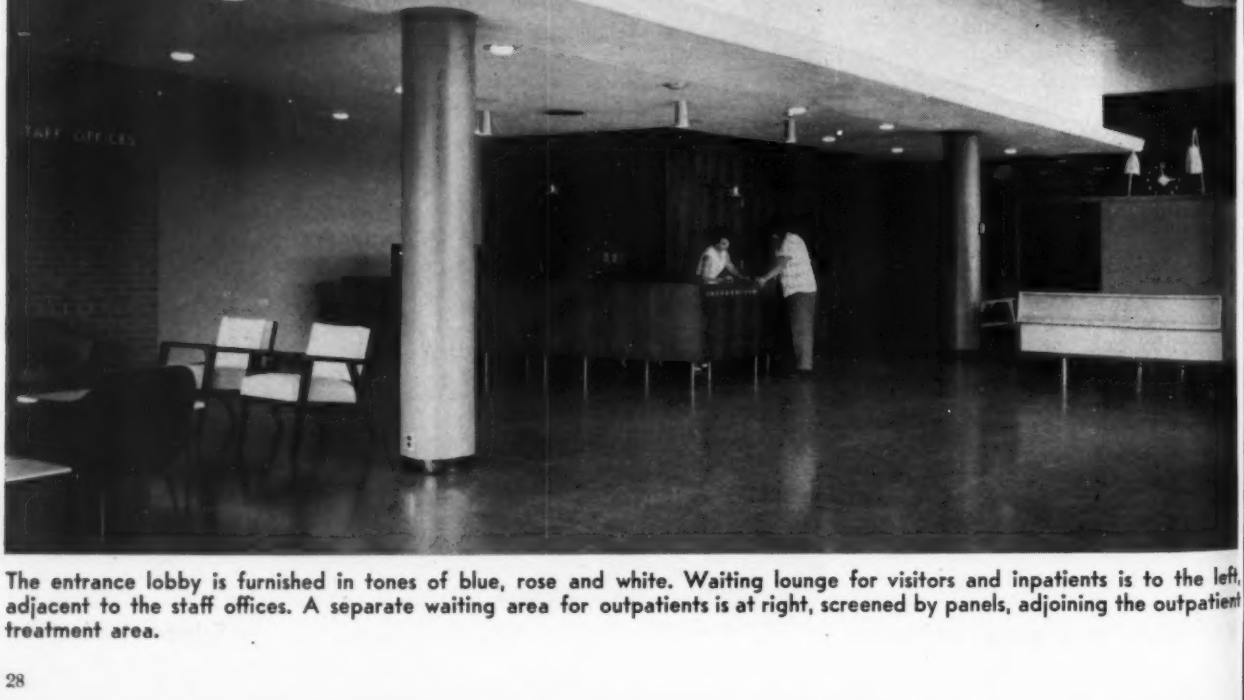
Entrance to the Clinic

The Organization and Programs of the Lafayette Clinic

By JACQUES S. GOTTLIEB, M. D., Director

THIS RESEARCH HOSPITAL came into being as a result of many forces: the citizenry of the State, as expressed through a bond issue; the Michigan Society of Mental Health; the Governor and his administrative staff; the Commission of the Michigan Department of Mental Health; Wayne State University, the Common Council of the City of Detroit; and the State Legislature. The legislative act creating this hospital placed it jointly under the Department of Mental Health of the State of Michigan and Wayne State University. The reason for this joint integration is that this hospital has been designated both as a training center for personnel in all the disciplines related to mental health and as a research hospital in the behavioral sciences. The legislative intent was that this hospital would develop not only its own training programs for residents in psychiatry, interns in psychology, students in social work, psychiatric nurses, and occupational therapy students, but would augment and amplify the training programs already in existence in various hospitals of the Department of Mental Health and eventually initiate additional programs in those hospitals and clinics where they are currently non-existent. Research was designated a major responsibility, which again only would not be conducted at the Clinic itself, but in which the staff of this hospital would participate as consultants in such programming as was occurring in the other hospitals and clinics of the Department of Mental Health. The legislative act creating this hospital contains many provisions conducive to the development of such an ambitious program, not the least of which is a controlled admission policy whereby only those patients need be selected as either inpatients or outpatients by the hospital staff to meet the training and research responsibilities of this unit. Such patients may be admitted as voluntary patients or through a probate court order, or on transfer from State hospitals and kept for treatment or study purposes up to a period of two years.

In order to carry out these functions, the professional staff of the Lafayette Clinic is being integrated academically with the corresponding departments of Wayne State University. The psychiatrists hold academic appointments in the Department of Psychiatry of the College of Medicine, the psychologists hold appointments in the Department of Psychology, certain social workers, nurses, and occupational therapists hold similar appointments in their corresponding departments, too. Not only, however, do members of the professional staff of the Lafayette Clinic hold appointments in their corresponding departments in Wayne State University and participate actively as members of those departments, but other academic personnel, members of various departments of Wayne State University, reciprocally hold part time appointments in the Lafayette Clinic. The



The entrance lobby is furnished in tones of blue, rose and white. Waiting lounge for visitors and inpatients is to the left, adjacent to the staff offices. A separate waiting area for outpatients is at right, screened by panels, adjoining the outpatient treatment area.

sociologists, psychologists, neuropathologists, biochemists, etc., are integrated into both teaching and research programming. To further augment the professional staff of the Lafayette Clinic selected individuals in practice in the community hold part time appointments.

Such integration is feasible because of the location of the Lafayette Clinic, which is in downtown Detroit, adjacent to the new building housing the College of Medicine of Wayne State University. It should be mentioned that this permits close integration with both the Detroit Receiving Hospital and the Detroit Memorial Hospital, both large general hospitals, which are also in the same medical area. The staffs of these latter hospitals, which comprise the teaching faculty of the College of Medicine, also function as the consulting staffs for the Lafayette Clinic. The augmentation, therefore, of the professional personnel of the Lafayette Clinic – through its integration with Wayne State University and the community of Detroit—makes it possible for this unit to structure its training and research programs to meet the legislative challenge.

The Lafayette Clinic is currently organized into a number of divisions and departments. The major divisions are: out-patient service for adults; inpatient service for adults; both outpatient and inpatient service for preadolescent and adolescent children; and a division of psychosomatic medicine. Currently being organized are divisions of psychoanalytic medicine, industrial and preventive psychiatry, and neurology. In addition to these clinical divisions are several laboratory divisions, including biochemistry, psychophysiology, neuropathology, and biometry. Departmentally, the hospital is divided into administration, psychiatry, psychology, social work, nursing, occupational therapy, and laboratories.

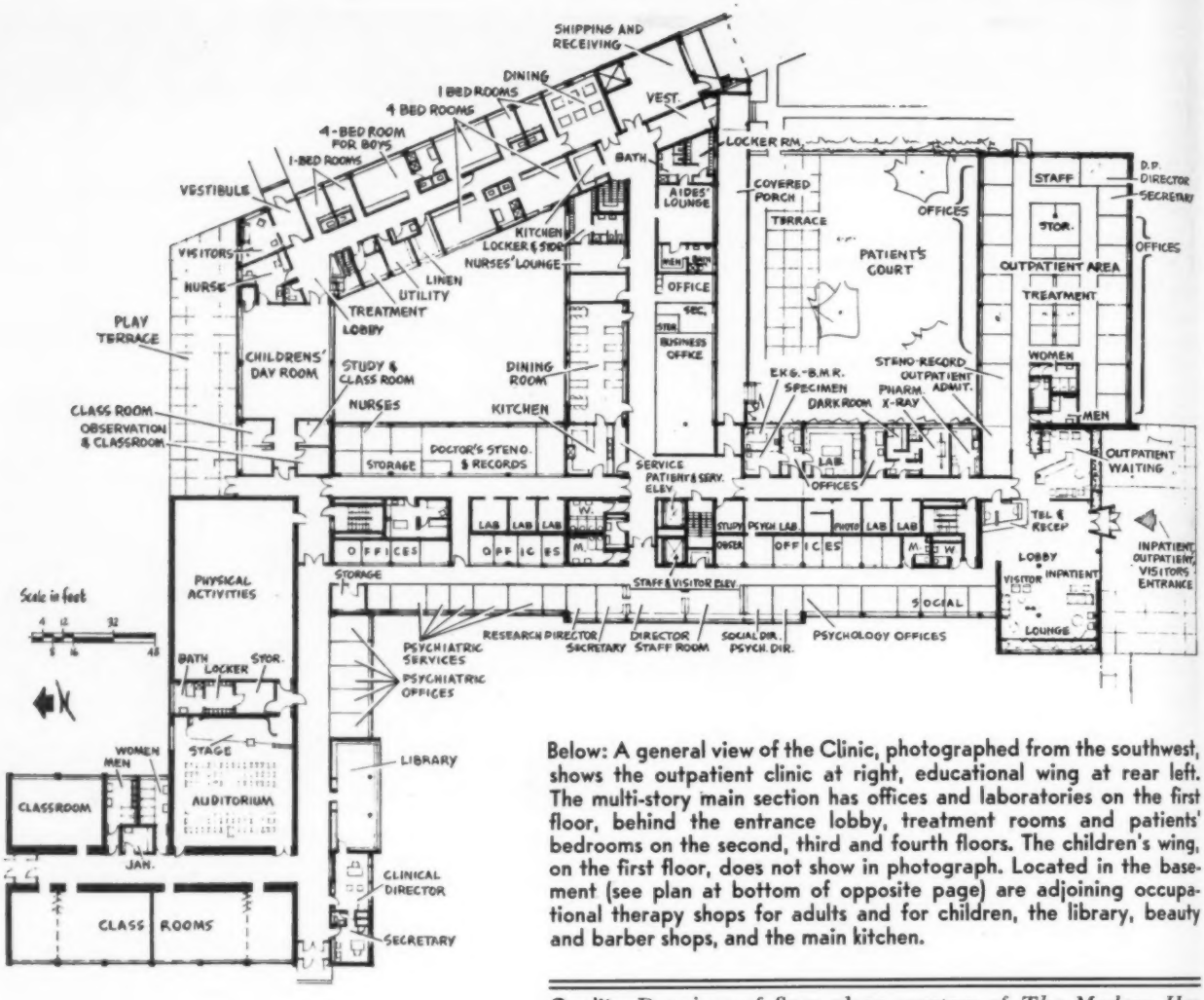
Interdisciplinary Emphasis

The philosophy of operation is in keeping with the primary goals of training and research, as training and research are our business. Good personal care of patients, of course, is accentuated by the scientific programs. Professional personnel have been and are being selected on the basis of their interest and ability to participate in training and investigative work, not on the basis of working in isolation, but as members of an interdisciplinary group. Both the training and the research programs being developed depend upon the integration of persons from various disciplines. Consequently, since all points of view are recognized, accepted, but put to test, this hospital can be considered eclectic in its orientation. Hence, the framework is all-inclusive, extending from detailed attention to the social and cultural factors involved with patient, family, and hospital employee relationships both in and out of the hospital through the usual intimate personal psychodynamic constellations, to the considering of the physiological and biochemical functioning of the patients as well.

Multiple training programs have been initiated. In psychiatry, there is the usual 3-year residency program; there is a 4-year residency consisting of two years in adult and two years in child psychiatry; and there is a 5-year residency, the last two years being structured to prepare the individual for a career in teaching and research. In addition, a 5-year contractual program is being developed, whereby the resident will spend three years in training at this hospital and two years in service at one of the other State institutions. Currently, in addition to the training of physicians to become psychiatrists, two of the large metropolitan hospitals in Detroit are rotating their residents in internal medicine through this hospital for experience in psychiatry. Also, residents in psychiatry have been assigned from other State hospital programs to this hospital to obtain their experience in child psychiatry. It is anticipated that residents in other programs in the State hospital system will be assigned here for other services to augment their own training.

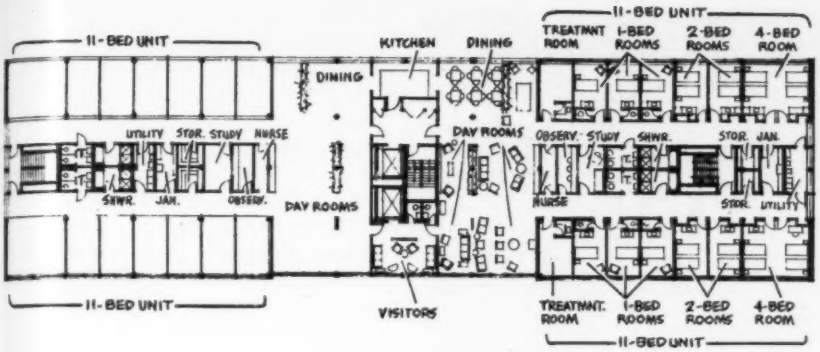
In addition, beginning this fall and

Through the windows of a day room for patients can be seen the Detroit Receiving Hospital. Photograph, which was posed by staff members, was taken before draperies and planting were installed (note planters lining the base of the window wall).



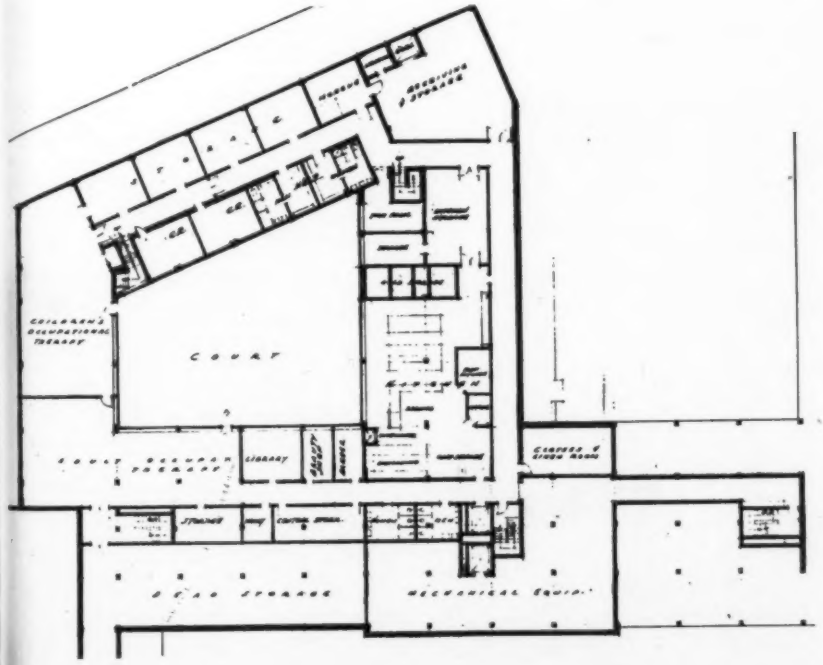
Below: A general view of the Clinic, photographed from the southwest, shows the outpatient clinic at right, educational wing at rear left. The multi-story main section has offices and laboratories on the first floor, behind the entrance lobby, treatment rooms and patients' bedrooms on the second, third and fourth floors. The children's wing, on the first floor, does not show in photograph. Located in the basement (see plan at bottom of opposite page) are adjoining occupational therapy shops for adults and for children, the library, beauty and barber shops, and the main kitchen.

Credits: Drawings of floor plans courtesy of *The Modern Hospital;* Photographs on pages 27, 28, 30, 32 by Hube Henry of Hedrich-Blessing.



Second and Third Floor Plans

Fourth Floor Plan



Basement Plan

running through the calendar year, will be a series of academic programs covering the psychiatric and neurological sciences which are designed to augment the training in the various residency programs in the State system, and to serve as refresher courses and workshops for the professional personnel not only in the State system, but in the community at large. This latter program has resulted from deliberations as to the existing needs as expressed by psychiatrists throughout the State.

In psychology, the usual one-year intern program is now in operation, and a post-doctorate fellowship program is being formulated. A workshop program for psychologists in both the State system and the community is also being planned.

Students in social work will learn something of research during the academic year, as well as gaining practical experience.

Nursing is involved in a number of programs ranging from collaborative training with the College of Nursing of Wayne State University for graduate psychiatric nurses, through other programs for practical nurses and psychiatric aides. Refresher courses and workshops for in-service training of personnel in the State system are also planned.

Research Goals

Concomitant with the development of the training programs has been the concerted effort on the part of the professional staff to develop research projects as well. Throughout the year —on a weekly basis—a seminar has functioned whose main purpose is to examine critically the detailed protocols which are presented in written form. Major investigative efforts have been directed into certain critical areas.

The first area of concern is the illness or illnesses designated schizophrenia. The approach to this problem is a multiple one. Consequently, projects have been developed pursuing various concepts and leads into the etiology, psychopathology, psychophysiology, and therapy of these conditions. In the area of biochemistry, studies are in process aimed at an investigation of the possibility of an enzyme disturbance in neurometabolism. At the psychophysiological level, the studies in progress relate

A nursing station, typical of those on the second and third floors, overlooks the day room at left and dining area at right (not shown). It has charge of the two eleven-bed units opening onto the corridors at rear.

the underlying psychodynamic constellation of the patient, as they are manifest in his physiological functioning. At the social level, there is an intensive and extensive study of the family constellation of the patients, which involves the cooperative efforts of sociologists, psychologists, social workers, and psychiatrists. The social and cultural environment is also being critically assessed in the rehabilitation of the chronic patient. One further area of concern is the study of the epidemiology of this and other disorders.

A second program of investigation has been formulated with respect to those factors responsible for defective functioning of the child. The causes of such conditions as mental deficiency, epilepsy, and cerebral palsy come together during the gestation period. Arrangements have been instituted for the study of variables that enter into this problem, in animals at laboratories being developed at one of the nearby State hospitals and in the laboratories of the College of Medicine. Participants in these studies will be psychiatrists, neurologists, experimental psychologists, biochemists, and neuropathologists.

Although projects have been formulated in the above two programs, other major programs have been designated by protocol, but as yet have not been definitively defined. In order, for instance, to study the primary process of treatment by the psychiatrist known as psychotherapy, an experimental chamber has been constructed in which the reactions of not only the patient but that of the therapist can be studied as well. Audio-visual sequences may be recorded through collaborative arrangements with the Department of Audio-Visual Education of Wayne State University.

Other programs, such as those in psychosomatic medicine and industrial psychiatry, await formulation.

The programming of the Lafayette Clinic in both training and research does not in itself make this a unique institution, but the Lafayette Clinic does perhaps differ primarily from other large training and research centers in its overall philosophy regarding its approach to the field of psychiatry. It is based upon the assumption that what is known is known, but that this is not enough; that more questions can be asked than can be answered; that we operate within a hypothetical framework which needs verification, amplification, and new constructs; that the scientific method can be applied to the complicated problems of the mentally ill; and that new knowledge and new treatment methods can be ultimately obtained for the benefit of mankind. The Lafayette Clinic hopes that ultimately it can make a contribution in these directions.

The staff library